



VITAL SIGNS

CANADIAN PHYSICIANS FOR LIFE NEWSLETTER

Summer 2004

Don't Call It Contraception By Will Johnston, MD

Supporters of the 'morning after pill' (MAP) express indignation that anyone would object to a simple emergency treatment to prevent pregnancy. Surely a woman deserves a chance for sober second thought in the cold light of dawn after being carried away by passion or suspecting betrayal by some imperfect birth control. After all, men risk no pregnancy – while, apparently, a bracing jolt of sex hormone is all it takes to level that unjust playing field called human reproduction.

Let us assume (naively, I fear) that easy access to the 'morning after pill' will prove not to increase promiscuity, risky sexual behaviour, disease and long-range hormonal side effects. Would a reasonable person object purely to the prevention of unwanted pregnancy, especially following a rape? This is the straw man set up by MAP promoters to force us to a foregone conclusion, because the real debate is not at all about prevention but about the meaning of a newly formed human life.

Until it suited them otherwise, MAP promoters would have agreed with everyone else that a woman is pregnant when she conceives. Now they deny the pregnancy until after their drug acts to kill it by preventing embryo implantation in the womb. This plays fast and loose with the plain English of the word "prevent," and patronizes the woman

who must make an ethical judgment, by assuming that she can't handle the truth. The fact is that the MAP is like shooting bullets through a closed door. If there happens to be someone on the other side, have you "prevented" their existence or just killed them?

This controversy would not exist except that some of us see inviolable worth in every human life no matter how small, while others do not. As our science rushes headlong into the age of embryo experimentation, this foundational ethical gap has become a chasm. We cannot let it go, we cannot overlook it, because the roots of our humanity are being shaken, the gale has begun to bend the tree. The next few decades will see great stresses placed on ancient human understandings of our origins and our purposes. We have launched ourselves into this adventure while tossing away the compass of respect for each life as worthy in itself, not as an object to be used. Just when our condition calls for humility, unprecedented licence is given to power.

Thus it is not a trifle when a pharmacist or doctor refuses to be part of the organized obfuscation required to call the MAP a contraceptive. Our society can ill afford to exclude persons of conscience from their professions, and women with hard choices to make deserve a clear look at the truth. ♦

'Morning After Pill' to be available in Canada without doctor's prescription

On May 18, Health Canada announced it was moving forward with plans to make the 'morning after pill' available in Canada without a doctor's prescription. It would be dispensed by pharmacists from behind the counter.

Responding to the news, Dr. Will Johnston, in a May 20 press release issued by Canadian Physicians for Life, expressed his concerns. "Physical and clinical examinations by a physician are essential to good healthcare: to counsel patients on how to reliably avoid pregnancy, to determine sexually-transmitted diseases and abusive or coercive relationships, and to discuss health risks. MAP does not protect against STDs and instead of preventing a pregnancy, may terminate it. Such serious issues cannot be adequately addressed at a pharmacist's counter."

Less than two weeks earlier, the US Food and Drug Administration rejected a plan to make MAP available over the counter at American pharmacies, citing a concern that no studies had been done to determine the safety of the drug for girls under 16 years of age. ♦

This article first appeared in the May 24 online edition of the National Post.

VITAL SIGNS

Canadian Physicians for Life Newsletter

VITAL SIGNS is published by Canadian Physicians for Life, a registered charitable organization. Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, "I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." We affirm this declaration.

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2004 Medical Students Forum and Canadian Physicians for Life AGM

In conjunction with the national pro-life conference

"Life 2004 – Alive and Loving It"

October 14-16, 2004

Delta Hotel, Winnipeg, Manitoba

Recognizing the profound importance of educating, encouraging, and exciting medical students about the "culture of life," Canadian Physicians for Life will be sponsoring a number of medical students to attend the national conference in Winnipeg this year. Students will have access to the main conference sessions (see program on opposite page) as well as additional sessions geared specifically towards medical students and physicians (shown in red on opposite page). The planning of these additional sessions is currently underway

This is a wonderful opportunity to bring together medical students and physicians who value the sanctity of human life, and to discuss how we can make an impact on society.

Here's what some medical students had to say about last year's forum in Edmonton:

"The networking was great, and I really like feeling supported by physicians who are out in the community."

"... it was very inspiring and gave me plenty to think about and I also feel more equipped in advocating pro-life. It's also great to meet other students from different schools and meeting physicians who obviously are very committed and have been through a lot...The knowledge and support I received gave me new directions in my future study and career...I hope we can carry on the vision for which you helped to lay the groundwork."

"...it was good to connect with other pro-life students as I think that we're a dying (or at least a quiet, well hidden) breed...Dr. Genuis's talk (was) both educational and...uplifting because he spoke of the positive aspects of following 'God's plan' for health and helped me to remember that as a doc I will be able to make a difference in individuals' lives."

"Thank you to the pro-life doctors for making this weekend possible for us. I appreciated being able to talk with you. It was educational and fun and we are all grateful for our new support network. Know that you are doing wonderful work..."

If you are a **medical student** and are interested in being sponsored for this event, please contact our office.

Canadian Physicians for Life members are invited to take part in this initiative by attending the conference and contributing to the costs of sponsoring medical students from across Canada. (Note: You may register for the CPL-sponsored sessions only, without registering for the main conference.) For more information or to register, please contact our office.

Canadian Physicians for Life Annual General Meeting

8 – 9 pm, October 15, 2004

Delta Winnipeg, 350 St. Mary Avenue, Winnipeg, Manitoba

CPL Members are invited to attend **Stephen Genuis's talk**,
"The Quest for Health and Wellbeing" prior to the AGM, from 7-8 p.m.

Annual National Pro-life Conference

Life 2004 – Alive and Loving It

October 14 – 16
Delta Hotel, Winnipeg, Manitoba

Thursday, October 14, 2004

10:00 a.m. - 11:00 a.m. Registration
11:00 a.m. - 12:30 p.m. Campaign Life Coalition Annual General Meeting
12:30 p.m. - 2:00 p.m. **LUNCH - on your own**
2:00 p.m. - 3:30 p.m. LifeCanada Annual General Meeting
4:30 p.m. - 5:30 p.m. Prayer Vigil - Women's Centre, Health Sciences Centre
5:30 p.m. - 6:30 p.m. **DINNER - on your own**
6:30 p.m. - 6:45 p.m. Welcome - MC
6:45 p.m. - 7:45 p.m. Jakki Jeffs, President of LifeCanada, *"Solidarity with Life Beyond Human and Natural Bonds"*
7:45 p.m. - 8:45 p.m. Vic Toews, MP/ **Dr. Will Johnston, Medical Students Welcome Address**

Friday, October 15, 2004

08:00 a.m. - 08:30 a.m. Registration
08:30 a.m. - 09:30 a.m. Robert Merrifield, MP, *"Ethical Shift in the 21st Century - A Political Perspective"*
09:30 a.m. - 10:00 a.m. **BREAK**
10:00 a.m. - 11:00 a.m. Christine Alarcon, *"Death by Prescription: Warring Perspectives on the Morning After Pill"*
11:00 a.m. - 12:00 p.m. Dr. Janice Mulder, *"Healing: The Hidden Potential in Palliative Care"*
12:00 p.m. - 1:30 p.m. **LUNCH - on your own / Medical Students Luncheon (registration with CPL office required)**
1:30 p.m. - 2:30 p.m. Scott Miller - workshop *"A Healing Model for Post-abortion men using the Twelve-Step Method"*
2:30 p.m. - 3:30 p.m. Ian Dowbiggan, *"Dead End: Lessons from the History of Euthanasia"*
3:30 p.m. - 4:30 p.m. Fr. Tom Lynch, *"When is enough enough: withdrawing food and water (good medicine vs. euthanasia, treatment vs. care)?"*
4:30 p.m. - 5:30 p.m. **BREAK**
5:30 p.m. - 7:00 p.m. Red River Welcome Reception (refreshments and finger foods)
7:00 p.m. - 8:00 p.m. Stephen Genuis, M.D., FRCSC., DABOG, *"The Quest for Health and Wellbeing"*
8:00 p.m. - 9:00 p.m. Jim Hughes, President, Campaign Life Coalition / **Canadian Physicians for Life AGM**

Saturday, October 16, 2004

08:00 a.m. - 08:30 a.m. Registration
08:30 a.m. - 09:30 a.m. Juergen Severloh, E.D., Crisis Pregnancy Centre, *"Loving Life from the Inside Out"*
09:30 a.m. - 10:30 a.m. Stephen Genuis, M.D., FRCSC., DABOG, *"The Sexual Revolution: Reality Strikes Back"*
10:30 a.m. - 11:30 a.m. Panel: *"It's About Life - That's the Truth"*, with: Lisa Johnston, Danielle Sanderson, Natalie Colton, Abel Pol.
11:30 a.m. - 12:30 p.m. **BREAK - on your own**
12:30 p.m. - 1:45 p.m. **BRUNCH** with speaker: Denise Mountenay, Canada Silent No More
2:00 p.m. - 3:00 p.m. Samantha Singson, CLC, *"Life at the UN"/ Dr. Larry Reynolds, Issues of Conscience*
3:00 p.m. - 4:00 p.m. Dr. Larry Rados, *"Contraception from a Pro-Life Point of View"*
4:00 p.m. - 5:00 p.m. Ian Gentles, *"Women's Health After Abortion"*
5:00 p.m. - 6:30 p.m. Mass at St. Mary's Cathedral with The Most Reverend V. James Weisgerber, Ph.L., S.T.L., D.D. Archbishop of Winnipeg
6:45 p.m. - 7:15 p.m. Cocktails - cash bar
7:15 p.m. Dinner Banquet with speakers Lech and Ewa Kowalewski, *"Abolition of Abortion - How it Works and What Happens Next - Poland"*
One of Many Stars Award

Program subject to change without notice.

Sponsored by **LifeCanada** and **Campaign Life Coalition**

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Abortion and Breast Cancer

Only fuzzy math can make the ABC link disappear

By Dr. Joel Brind

It looks like “déjà-vu all over again”: A supposedly definitive study of immense statistical power, published in a top medical journal, has once again proven the abortion-breast cancer link (ABC link) nonexistent.

This time (March 25 of this year) it was “a collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries.” It was authored by a prestigious group of Oxford researchers, and published in the *Lancet*, one of the most prominent medical journals in the world. And lead author Valerie Beral wasted no time hyping her group’s findings in a frenzy of pre-publication interviews. For example, she told the Associated Press: “The totality of the worldwide epidemiological evidence indicates that pregnancies ended by induced abortion do not have adverse effects on women’s subsequent risk of developing breast cancer.”

“Scientifically, this really is a full analysis of the current data,” Beral told the Atlanta Journal-Constitution, suggesting a truly comprehensive review of the data.

To say that the Beral study is seriously flawed and that its conclusions do not stand up to close scrutiny is to understate seriously the magnitude of what is really going on here. For starters, the claim that this is a “full analysis” is flatly false. Let’s just do the simple math. We start with 41 studies which showed data on induced abortion and breast cancer, dating as far back as 1957. Then how do we get to 53 studies? (Actually, the total is 52 studies.) We add 11 studies worth of unpublished data, right? That might be okay, but it wasn’t what was done. What Beral et. al. actually did was:

Throw out two studies for the scientifically appropriate reason that “specific information on whether pregnancies ended as spontaneous or induced abortions had not been recorded

systematically for women with breast cancer and a comparison group.” Specifically, one such study from Sweden in 1989 used general population statistics for comparison, instead of a control group, and one US study from 1993 ascertained abortions only indirectly, by subtracting the number of children from the number of pregnancies.

Throw out 11 more perfectly good studies for reasons such as: “Principal investigators ... could not be traced” (We can’t find Professor Einstein, either. Does that mean we throw out relativity?); “original data could not be retrieved by the principal investigators”; “researchers declined to take part in the collaboration”; or investigators “judged their own information on induced abortion to be unreliable” (even though it had been published in a prominent medical journal).

Finally, four studies’ worth of data (one on French women, one on Chinese women, one on Russian women, and one on African-American women) were simply not even mentioned, even though they had been previously published as abstracts or included in other reviews.

That brings the total down from 41 to only 24 studies. Now we add 28 studies worth of unpublished data, and Voilà! We have 52 studies. The fact that the majority of studies have not stood the test of peer review is troubling enough. But a closer look at the excluded studies is even more revealing.

Of the 41 studies which have been previously published, 29 actually show increased risk of breast cancer among women who have chosen abortion. (Epidemiologists call this a “positive association.”) Sixteen of these are statistically significant, which means there is at least a 95% certainty that the results cannot be explained by chance. Getting back to Beral’s “full analysis,” 10 of the 16 significantly positive studies in the literature were excluded for

one of the unscientific reasons cited above. In fact, if we average all of the 15 studies Beral excluded for unscientific reasons, they show an average breast cancer risk increase of 80% among women who had chosen abortion.

So if we just add up all the studies Beral’s group decided selectively to include, we get no significant effect of abortion on breast cancer risk. But we haven’t even gotten to Beral’s main argument yet. She actually divided the included studies into two types; those which used retrospective methods of data collection (i.e., interviews of breast cancer patients v. control subjects), and those which used prospective methods (i.e., medical records taken long before breast cancer diagnosis). The retrospective data-based studies are thought to be less reliable, because, as Beral told the *Washington Post*, women with breast cancer “are more likely than healthy women to reveal they had an abortion, leading to the conclusion that there are more abortions among this group.”

Readers may recognize this “reporting bias” or “response bias” argument, used for over a decade now to dismiss the overwhelming majority of studies (which are retrospective data-based) which reveal an ABC link. It is actually a hypothesis worthy of testing. The trouble is, tests for such bias have proven negative over and over and over again in the published literature, in studies as far flung as Japan, the US, and Greece. In fact, Beral still reaches back to a 1991 Swedish study, which was the only one ever to claim direct evidence of such “reporting bias.” However, that study’s conclusion depended upon the assumption – since publicly retracted by the original authors – that breast cancer patients had “overreported” abortions (i.e., reported abortions that had never taken place).

That brings up another serious flaw in the Beral study, specifically, the exclusion of any published critiques of studies she found acceptable. She included uncritically, for example, data from a 1990 study on Norwegian women which had found no link. How-

(Continued on page 5...ABC link)

(ABC link...continued from page 4)

ever, in 1998 our own group published a rigorous, mathematical proof that those data were incorrectly compiled, and had actually indicated increased risk among Norwegian women.

Getting back to the reporting bias argument, Beral separately compiled all the studies that used prospective methodology (13 studies) and those that used retrospective methods (39 studies), and found the results to be significantly different. Specifically, the former showed a significant overall 7% decrease in risk with abortion, while the latter showed a significant overall 11% increase in risk.

Beral's conclusion? "We have demonstrated that a certain group of studies (the ones with retrospective data) are unreliable and can't be trusted," she told the *Washington Post*.

There are only two things wrong with that conclusion:

First, it is completely illogical to leap to the conclusion that, just because there is a difference in the overall results reached by the two types of studies, that the difference is caused by reporting bias. This is especially true in light of the fact that such bias has been repeatedly demonstrated NOT to exist.

Second, at least three of the prospective data-based studies are so seriously flawed themselves as to merit exclusion from the Beral study on the basis of information on abortions having "not been recorded systematically" (see above). Specifically, these studies included the 1997 Melbye study from Denmark, in which ALL the data on legal abortions before 1973 were missing (only 80,000 abortions on 60,000 women!); a 2001 study in the UK (an Oxford University study, no less) in which over 90% of the abortions in the study population were unrecorded; and a 2003 Swedish study in which data on all abortions after the most recent childbirth were missing. (In Sweden, where abortion is used predominantly to limit family size, that means most of the abortion records for women in the study were missing.) We have published detailed critiques of these studies but, as noted above, these critiques are not cited in Beral's "full analysis."

Another telling aspect of the Beral paper is the graphic depicting the compilation of studies. As noted above, most of the studies which showed significant elevations in risk with induced abortion were inappropriately excluded from the analysis. Then, by combining certain groups of studies and graphing them as "other," it is made to look AS IF NO STUDY EVER FOUND A RELATIVE RISK HIGHER THAN 1.4! In fact, six studies (two on Japanese women, two on African-American women, one on Chinese women and one on Australian women) have reported overall relative risks greater than 2.0 (i.e., more than a 100% risk increase with abortion).

Finally, I believe an editorial note is in order, because the knee-jerk reaction of so many is to put credence in studies that come from such high places as the *Lancet* or the *New England Journal of Medicine* or the National Cancer Institute. As one who has been doing battle on the ABC link in medical and scientific journals and in other public fora for over a decade, nothing has been more obvious to me than the systematic denial of the link from organized science and medicine. In fact, the first study which was specifically designed to "reassure" the public about the safety of abortion vis-à-vis breast cancer was published way back in 1982, and originated from the same cancer research epidemiology unit at Oxford's Radcliffe Infirmary as Beral's "full analysis."

But if the reader would remain skeptical of this writer's observations and conclusions, consider this. It is undisputed – even by Beral herself – that a full-term pregnancy lowers a woman's long term risk of breast cancer, and that this protection is not afforded by a pregnancy that ends in induced abortion. Yet Beral and most of mainstream science and medicine would refuse to say that abortion is therefore a risk factor. In fact, the studious avoidance of characterizing abortion in this way is obvious in the very caption of Beral's summary chart: "Relative risk of breast cancer, comparing the effects of having had a pregnancy that ended as an induced abortion versus effects of never having

had that pregnancy." If the same convoluted standard were used in characterizing hormone replacement therapy (HRT) for postmenopausal women, it would also not show up as a risk factor. Specifically, using the same standard would mean comparing postmenopausal women using HRT to premenopausal women of the same age. The conclusion of such a study would be that women using HRT have no greater risk of breast cancer, compared to not having gone into menopause. Instead (and this is no more clearly stated than in Beral's own "Million Woman Study" on HRT and breast cancer, published last year), the study is restricted to postmenopausal women, with those taking HRT thus compared to women who get virtually no estrogen and progesterone at all, from inside or outside. So of course HRT shows up as a risk factor – as well it should.

Everyone knows – including Beral – that a woman who chooses abortion will end up with a higher long term risk of breast cancer than would result from the childbirth choice. Still, unethical and outrageous as it is, it is politically incorrect to inform women seeking abortion of this undeniable truth. ♦

This article appears on the website of the Coalition on Abortion/Breast Cancer, www.abortionbreastcancer.com. Reprinted with permission of the author.



In this video, you will hear the convincing scientific evidence presented by two acknowledged world experts on the Abortion Breast Cancer Link: Dr. Joel Brind, PhD, Professor Human Biology and Endocrinology, and Dr. Angela Lanfranchi,

MC FACS, Clinical Assistant Professor of Surgery at Robert Wood Johnson Medical School. The information on this video will empower women to make informed choices for themselves and their children.

Available through LifeCanada in both VHS and DVD format at a cost of \$30.00 per video or \$25 each for 3 or more. To order, contact:

LifeCanada:
Ph: (613) 722-1552 or
email: info@lifecanada.org

MaterCare International

The Health Care of Mothers

By Dr. Robert L. Walley, FRCSC, FRCOG, MPH (Harvard)

Mothers in poor countries are experiencing “unimaginable suffering” through the lack of effective care during pregnancy and labour resulting in almost 600,000 dying annually. Ninety-nine per cent of these deaths occur in developing countries. The risk of a mother dying as a direct result of pregnancy and labour in Africa is 1:13, whereas the risk in Canada is 1:7,300. It has been said (UNICEF 1996) that it is “one of the most neglected tragedies of our times, when 1,600 mothers – some in their teens – die every day, when most of these deaths are readily preventable.” These deaths do not take place in a visible and concentrated way, but occur to very young women, in small villages, and a few at a time. Most die in terror from haemorrhage or in agony from obstructed labour as their pelvises are too small. Not only are the lives of these women abruptly terminated, but the chances of survival of their new-borns and their young children decrease dramatically. It is also likely that the family itself disintegrates in the aftermath of the mother’s death.

Sadly, deaths from childbirth related causes represent only the tip of the iceberg. It is estimated that for every death, 30 more mothers suffer long-term damage to their health, commonly from obstetric fistulae. These arise in very young mothers, frequently as a consequence of neglected obstructed labour. This results in the death of their babies and, at the same time, damage to the bladder and rectum which leaves the mothers incontinent of urine and/or faeces (obstetric fistula), and as a consequence, complete outcasts, being treated worse than lepers by husband, family, and society, simply because

they are wet and offensive. They suffer pain, humiliation, and lifelong debility if not treated. World-wide, there are two million untreated cases, mostly in Africa. The tragedy is that most of this mortality and morbidity is preventable with proper maternity care, and obstetric fistula can be treated surgically, but at present there are not enough trained doctors, nurses, or adequate facilities.

In Canada, abortion has become the basis of the health care of mothers. We must be quite clear about what is happening, it is no less than the carnage of the unborn child. Despite the many advances in modern perinatal medicine and obstetrical care which have almost eradicated maternal deaths and markedly reduced perinatal deaths over the last twenty five years, abortion has resulted in the deaths of over two million unborn Canadian babies. It is no less than the carnage of the unborn child aided and abetted by many in our profession who now provide their skills in hospitals that carry out more abortions than normal deliveries. It is a policy which arises from the poverty of medical and moral thought and, more seriously, a poverty resulting from a lack of love. All of this has brought a once noble profession to a state of crisis as not enough medical graduates are entering ob/gyn residency training programmes to meet current needs.

MaterCare International (MCI) was founded in 1995 to bring about a sort of renaissance in the practice of obstetrics by breathing life back into the specialty. MCI has been organized with the objective of putting mothers first. The mission is to care for mothers and babies, in both developing and developed countries through the provision of new initiatives in service, training, research, and advocacy, but the fundamental differences between MCI and other professional agencies are the ethics in which it is rooted, i.e., those contained in Pope John-Paul’s Encyclical, *Evangelium Vitae* (the Gospel of Life).

In 1997, MCI began its work with a rural, essential obstetrical, and obstetric
(Continued on page 7...MCI)

MaterCare International (MCI) and the World Federation of Catholic Medical Associations (FIAMC) Third International Workshop

Oct 13 –17

The Maria SS Bambina Centre,
Rome, Italy

OBJECTIVES

To consider the:

- evidence and ethical considerations concerning current controversial issues in obstetrics and gynaecology.
- biology and ethical concerns and alternative ethical sources of stem cells.
- ethical treatments for male and female infertility.
- scientific foundations, practice and training in natural family planning.
- organization, function, and activities of MCI and its national affiliates.
- technology and techniques available for distributive distance learning via the internet with course examples.
- organization, role, and projects undertaken by MaterCare International.

To provide an opportunity to make and renew friendships.

PARTICIPANTS

Open to obstetricians/gynaecologists, representatives from MCI, FIAMC, CICIAMS, and other interested church, medical, bioethical and legal organizations, specialists in training, medical students, Catholic women’s organizations, pro-life groups, political leaders and media representatives.

REGISTRATION

For more information, or to register for the workshop and book accommodation, please contact:

Mr. Simon Walley
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(MCI...continued from page 6)

fistula project in Ghana consisting of the following programmes: training traditional birth attendants (TBAs) in villages to recognize and refer high risk mothers to the mission hospital using a pictorial antenatal card; training nurse/midwives in rural 11 maternity centres to use the labour partograph; and linking them to the mission hospital and an emergency transport system by radio. The evaluation of this programme shows that, through increased referrals of mothers at risk, maternal mortality can be substantially reduced, and that this rural maternity care system is relevant anywhere with poor communications, transportation, and medical care.

A research programme has been completed which evaluated the safety of misoprostol, an oral prostaglandin as an effective and inexpensive method of managing life threatening postpartum haemorrhage, which can be used safely by TBAs when medical aid is not available.

An important initiative in 2004 is the construction of a 40 bed Birth Trauma Centre for fistula treatment and rehabilitation programmes. The centre will also have a special interest in the training of doctors and nurses from Ghana and other West African countries in the surgery and nursing management of obstetric fistula, thus ensuring sustainability of treatment services through local capacity building. This centre, to be located near Accra, the capital of Ghana, will cost US\$2 million to construct and operate for five years.

MCI was also concerned about the

health care of Kosovar mothers in northern Albania. In East Timor in 2003, MCI began providing training courses for midwives and nurses, to be repeated this year with the addition of a course for doctors. An essential rural obstetrical service, similar to the Ghanaian service, is also being planned as there are no obstetricians in the country and only one general hospital for a population of 700,000. Other requests for help have come from Sierra Leone and Rwanda. MCI has been legally established in Canada, Ireland, the UK, the European Union, the United States, and Australia and has been formally recognized by the United Nations as a Non-Governmental Organization (NGO).

MCI is not simply providing services in developing countries. In 2001, MCI organized its first international workshop in Rome where 140 ob/gyns from 40 countries discussed the "Right to be Trained and to Practice According to Conscience." A second conference was held in 2002, and the third will be held in 2004. As a result, MCI has developed a task force to establish an international specialist training programme for doctors from countries where, in order to train as a specialist, they are required to carry out abortions. MCI is also developing distance learning programmes in medical ethics, natural family planning, and the management of obstetric fistula.

The problems of women's health and the need for improved care have been discussed by the international community for some years, but little has been done. It is a disgrace that so many poor mothers should die or have

to endure this ultimate of indignities – incontinence – when treatment is available, or that so many should have little alternative other than abortion to solve social problems. The facts are that maternal mortality is not of political importance as are land mine injuries or AIDS. Mothers who are at risk are young, poor, and without a voice to speak on their behalf. While billions of dollars have been spent on abortion and birth control programmes, only a small fraction is provided for necessary maternity services which are a basic human right – services freely available to all mothers in rich countries if they want them. The former Director General of WHO, Dr. Halfdan Mahler, commented in 1987, "We know enough to act now, it could be done; it ought to be done; and in the name of social justice and human solidarity, it must be done."

In his address to MaterCare's first International Conference in June 2001, Pope John-Paul II said;

"It is my fervent hope that at the beginning of this new millennium, all Catholic medical and health care personnel, whether in research or practice, will commit themselves whole-heartedly to the service of human life. I trust that the local Churches will give due attention to the medical profession, promoting the ideal of unambiguous service to the great miracle of life, supporting obstetricians, gynaecologists and health workers who respect the right to life by helping to bring them together for mutual support and the exchange of ideas and experiences."

MCI is challenging the professional status quo and thus has few friends. It needs support from multi-disciplined health professionals, as well as financial and political support and, most importantly, the prayers of everyone. ♦

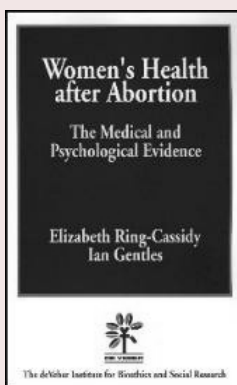
Dr. Walley is Executive Director of MaterCare International and Honorary Research Professor of Obstetrics and Gynaecology. For more info on MCI, visit: www.matercare.org.

Women's Health after Abortion

The Medical and Psychological Evidence

Can be ordered directly from the publisher:
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www.deveber.org

See reply card to receive a copy from Canadian Physicians for Life



Med School 101: You Must Perform or Refer for Abortion

By Paul Ranalli, MD

In March of this year, LifeSite News reported that a Manitoba student in his final year of Medical School would be denied his degree for his “unwillingness to partake in any abortion-related activity.” This was despite the fact the student had achieved high grades in every area of study and “strong words of affirmation from clinical supervisors,” according to a friend of the family, LifeSite News reported. Three appeals within the Faculty of Medicine were unsuccessful. The ordeal caused undue anxiety for the student and his family and lasted several months. Then in April, for reasons which are not entirely clear, the University reversed its decision and the student graduated in May. In this article, Dr. Paul Ranalli reflects on his own experience in Medical School when he, too, faced the threat of failure for refusing to be involved with abortions.

The Manitoba story stirred memories of my own mercifully brief experience as a final-year medical student at the University of Toronto in the spring of 1979. In one of the final clinical rotations of the year before being awarded my MD degree, I spent four weeks assisting at deliveries and gynecological surgery at a large downtown Toronto teaching hospital.

Fortunately, the attending staff were careful to point out that student attendance at abortions was purely voluntary. At the end of the four-week session came the examination, a fairly straightforward 20-question multiple-choice quiz.

Although my interest lay in internal medicine (and eventually the subspecialty of neurology), the test was easy enough. But one question caught my eye. It went something like this:

For a woman with an unwanted pregnancy at 14 weeks gestation which of the following methods of termination would you choose?

*dilation and evacuation (D&E)
dilation and curettage (D&C)
saline instillation and extraction
hysterotomy and evacuation*

I drew an “X” through the question (intentionally forfeiting the points for that question) and neatly wrote in the margin, “I would not choose any of the above, as I would not counsel or perform an abortion.” I thought this would be the quietest, most respectful method of sidestepping the question out of conscientious objection.

I was naïve. Later that afternoon, as I relaxed between deliveries, I heard the clipped stride of well-polished shoes down the ward corridor. A tall man came around the corner: it was Dr. P., although I could scarcely recognize the transformation in him.

His face was flaming red, the veins in his neck bulged out from the starched collar of his shirt. He tore into me for my insolence and presumption for writing such a thing on the exam paper.

Who did I think I was, he told me? Didn’t I realize that women *needed* an abortion, and it was the duty of every doctor to provide service to his patients?

He asked if I was a Catholic. I told him it was not his business to ask, but I had no hesitation in telling him that I was. He then straightened his shoulders and said that he, too, was a Catholic, and so was Dr. B., the chief of the department, and although it wasn’t easy for them, they did not shirk from *doing their share* of abortions.

I’ll admit I was at first set back on my heels. But I refused to be intimidated. I was, however, stunned at how raw a nerve seemed to have been touched in the man.

Until that moment, I had not been exposed to the hair-trigger defensiveness of many physicians who make it their practice to commit abortions. Earlier in the rotation I had come to know and appreciate Dr. P., whose story was an interesting one.

He was an obstetrician at a small rural hospital in one of Canada’s rustic

Maritime provinces before applying for the promotion to a big-city university position. It occurred to me later that abortions were likely not allowed at the small hospital where he had earlier practiced, so he could concentrate on his first love: delivering babies.

Perhaps he was already feeling the internal conflict between his professional ambition and the concomitant need to “do his share” of abortions at this large secular city hospital. If so, the guilt must have been awful. I certainly did not envy his position; perhaps he actually envied mine.

As his tirade went on, I began to feel sorry for Dr. P. I surprised myself at how I felt unexpectedly powerful, not a common emotion for a lowly medical student. I snapped to attention at his parting words: “I could fail you for this!”

I quietly responded, “Do what you have to do.” He blinked, turned, and strode off.

Of course, I passed. No one ever mentioned the incident again.

A few years later, curiosity got the better of me as I looked up another physician whose name began with the letter P. I flipped the page and looked down the column to find the obstetrician Dr. P. I noted that he was no longer at the big-city teaching hospital. He had moved his obstetrics practice back to a small town. ♦

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“A modern democracy should have a keen interest in protecting vulnerable students from coercion by preceptors and professors who are unaware of, or insensitive to, the concept of freedom of conscience. We don’t screen immigrants to Canada on the basis of race or religion. Why should such litmus tests be applied to citizens applying to enter key professions? Ethics profiling is no less objectionable than racial profiling.”

Dr. Will Johnston in a May 12, 2004 statement on conscience legislation. See the full statement at www.physiciansforlife.ca/May12_04_Press_conscience.htm